The Therapeutic Lie: A reflective account illustrating the potential benefits when nursing an elderly confused patient

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*The patient's name has been changed and Nursing & Midwifery Council (NMC) confidentiality guidelines and procedures fully observed

SITUATION:

The circumstances involved an extremely anxious, frustrated and distressed man named John, with a severe cognitive impairment. John was an inpatient on a dementia ward in a mental health hospital in the southwest of England, who wanted to use the telephone to contact his long-deceased mother. One of the authors' works as a staff nurse on the ward, who after recognising that John was disorientated to time, place and person, lacked capacity around his health and wellbeing, and had no insight into his own confusion, wondered whether a therapeutic lie might be employed, both to effectively engage with and minimise his distress and preserve his dignity.

BACKGROUND:

John was detained under Section 2 of the Mental Health Act (2007) whilst the extent of his cognitive impairment and probable dementia was assessed and determined. His family and friends were struggling to maintain his safety and happiness at home, where he had been increasingly endangering himself and telephoning emergency services regularly and inappropriately. This was compounded by his regular ventures into the local community where he had invariably got lost, was confused, had no money, was looking for his mother, and required police support until relatives could be contacted. Consequently, John was admitted into hospital and had spent the last few weeks on the ward. Whilst on the ward he was continually requesting to use the telephone to contact his mother and was unable to accept explanations from both staff and family as to why this was not possible. Anxiolytic medication was being utilized during the weeks of his admission to alleviate his distress when circumstances became extreme. There appeared, as is so often the case in dementia, to be no logic to his repetitive fixation.

ASSESSMENT:

The rationale for the therapeutic lie and associated ethical issues were discussed by the multi-disciplinary team, and a consensus was reached to take a positive risk. It was decided that when distress was not reduced by other interventions, John would be offered the opportunity to telephone one of his daughters, whilst telling him he

was calling his mother. The ward advocate, an independent party, was involved in the decision, so to ensure that John's best interests were being sought and to promote the individuality of the situation. His daughters were familiar with him telephoning and believing he was speaking with his mother. Once the situation had been thoroughly discussed and a decision made that the truth about his mother's death many years earlier was counter-therapeutic, a care plan was accordingly constructed by the author and colleagues. John would be given opportunity to telephone his mother on request, and many distraction techniques were also built-in to the care plan, essentially expanding the therapeutic lie to accommodate excuses for why it was not possible at certain times to telephone.

DISCUSSION:

According to the NMC Code of Conduct, it is imperative for nurses to: Prioritise people – Practise effectively – Preserve safety – Promote professionalism and trust. There is clearly an ethical issue here relating to professionalism and trust, since a lie is being told to the patient, irrespective of it being regarded as therapeutic. The use of a therapeutic lie to alleviate John's distress and anxiety is contextualized by his lack of mental capacity, which is unlikely to be regained, except for brief periods. The situation is complicated further by Turner et al (2016)'s observation that staff belief in therapeutic lying under certain circumstances might result in inconsistent care delivery and confused communication strategies. This practice of deliberately deceiving John for reasons considered to be in his best interests, the definition of a therapeutic lie (Sperber, 2015), is conceptualized in this way because of the desire both to eliminate any harm potential but also control behaviour (Rahman, 2017). Unfortunately, there are currently no formal published guidelines in the UK justifying the use of the therapeutic lie with people with dementia, yet the approach is sometimes justifiable and perhaps pervasive (Culley et al., 2013). It is not uncommon, for example, to avoid telling people that their relatives are dead (Mental Health Foundation, 2014), but there is a clear absence of consistency, with contradictory qualities, such as openness and honesty, regularly accentuated (NMC, 2008).

CONCLUSION:

The use of the therapeutic lie must be in the best interests of the patient, should be risk assessed, and based on a consensus of professionals, family and advocate. Once it has been integrated into the person's care plan, the approach can genuinely reduce distress, anxiety and behavioural psychotic symptoms of dementia. Finally, it might be fruitful to engage the person with dementia during the early stages of the condition to contribute to an advanced directive in relation to future risks and care needs.

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